Department of Corrections
WASHINGTON STATE

CHEMICAL DEPENDENCY CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I _____ DOC #: _____ authorize

_____ to disclose to
Name of person or general designation of alcohol/drug program making disclosure

_____ the following information:
Name of person or organization to which disclosure is made

_____ _____
Address of person or organization to which disclosure is made Fax Number

(Please initial all that apply)

_____ Chemical Dependency (CD) Assessment/Admission information including Summary Impression and Level of Care Placement
_____ CD Treatment Plan and Progress in Treatment
_____ CD Discharge/Transfer Summary and Information
_____ Participation and attendance in CD treatment
_____ Compliance/Non-compliance with CD treatment requirements
_____ DOC #13-310 Chemical Dependency Monthly Status Report
_____ Other (specify) _____

The purpose of this disclosure authorized herein is to:
(Please initial all that apply)

_____ Obtain information to assist in my initial or continued care plans
_____ Obtain information to assist in obtaining my drivers license
_____ Other (specify) _____

If I am subject to the jurisdiction of the Indeterminate Sentence Review Board (ISRB), this consent will terminate upon the expiration of my maximum sentence or the granting of a final discharge. If I revoke this consent prior to the expiration of my maximum sentence or the granting of a final discharge, I understand the ISRB will obtain a subpoena and court order that complies with 42 CFR, Part 2 requiring disclosure of the relevant portions of my chemical dependency records.

Initials _____

If I am an SRA offender, this consent will terminate upon the expiration of my Prison sentence and any post-release supervision.

Initials _____

I understand that my records are protected under federal regulations governing confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2, and cannot be further disclosed without my written consent unless otherwise provided for in the regulations.

I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment, or eligibility for benefits) except for health care services necessary to create any assessment or report for disclosure to the recipient identified in this authorization.

I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will expire at the end of the term of Department of Corrections supervision, 60 days following discharge from the treatment program or 90 days from the date of this signed consent, whichever is later.

_____ _____ _____
Patient/Offender Signature DOB Date

_____ _____
Witness Signature Date

The records contained herein are protected by Federal Confidentiality Regulations 42 CFR Part 2. The Federal rules prohibit further disclosure of this information to parties outside of the Department of Corrections unless such disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Distribution: **ORIGINAL**–CD File **COPY**–Offender
DOC 14-303 (Rev. 03/01/13) DOC 280.500, DOC 670.500